D. ELIGIBILITY REQUIREMENTS

WAC 388-513-1315 Eligibility for long-term care (institutional, waivered, and hospice) services.

This section describes how the department determines a client's eligibility for institutional, waivered, or hospice services under the categorically needy (CN) program and institutional or hospice services under the medically needy (MN) program. Also described are the eligibility requirements for these services under the general assistance (GA) program in subsection (10) and emergency medical programs described in subsections (9) and (11).

(1) To be eligible for long-term care (LTC) services described in this section, a client must:

(a) Meet the general eligibility requirements for medical programs described in WAC 388-503-0505 (2) and (3) (a) through (f);

(b) Attain institutional status as described in WAC 388-513-1320; and

(c) Not be subject to a penalty period of ineligibility as described in WAC 388-513-1365 and WAC 388-513-1366.

(2) To be eligible for institutional, waivered, or hospice services under the CN program, a client must either:

(a) Be related to the Supplemental Security Income (SSI) program as described in WAC 388-503-0510 (1) or be approved for the general assistance expedited Medicaid disability (GA-X) program; and

(b) Meet the following financial requirements, by having:

(i) Gross non-excluded income described in subsection (7) (a) that does not exceed the special income level (SIL); and

(ii) Non-excluded resources described in subsection (6) that do not exceed the resource standard described in WAC 388-513-1350 (1), unless subsection (3) applies; or

(c) Be eligible for the CN children's medical program as described in WAC 388-505-0210; or

(d) Be eligible for the temporary assistance for needy families (TANF) program or state family assistance (SFA) program as described in WAC 388-505-0220.

(3) The department allows a client to have non-excluded resources in excess of the standard described in WAC 388-513-1350 (1) during the month of either an application or eligibility review if, when excess resources are added to non-excluded income, the combined total does not exceed the SIL.

(4) To be eligible for waivered or hospice services, a client must also meet the program requirements described in:

(a) WAC 388-515-1505 for COPES services;

(b) WAC 388-515-1510 for CAP and OBRA services;

(c) WAC 388-515-1530 for CASA services; or

(d) Chapter 388-551 WAC for hospice services.

(5) To be eligible for institutional or hospice services under the MN program, a client must be:

(a) Eligible for the MN children's medical program as described in WAC 388-505-0210; or

(b) Related to the SSI program as described in WAC 388-503-0510(1); and meet all requirements described in WAC 388-513-1395.

(6) To determine resource eligibility for an SSI-related client under the CN or MN program, the department:

(a) Considers resources available as described in WAC 388-513-1350;

(b) Excludes resources described in WAC 388-513-1360, WAC 388-513-1365, and WAC 388-513-1366; and

(c) Compares the non-excluded resources to the standard described in
(i) WAC 388-513-1350 (1).

(7) To determine income eligibility for an SSI-related client under the CN or MN program, the department:

(a) Considers income available as described in WAC 388-513-1325 and WAC 388-513-1330;

(b) Excludes income for CN and MN programs as described in WAC 388-513-1340;

(c) Disregards income for the MN program as described in WAC 388-513-1345; and

(d) Follows program rules for the MN program as described in WAC 388-513-1395.

(8) A client who meets the requirements of the CN program is approved for a period of up to twelve months for:

(a) Institutional services in a medical facility;

(b) Waivered services at home or in an alternate living facility; or

(c) Hospice services at home or in a medical facility.

(9) A client who meets the requirements of the MN program is approved for a period of months described in WAC 388-513-1395 (5) (a) (ii) for:

(a) Institutional services in a medical facility; or

(b) Hospice services at home or in a medical facility.

(10) The department determines eligibility for LTC services under the alien emergency medical (AEM) program described in WAC 388-438-0110 for a client who meets all other CN requirements for such services but does not meet citizenship requirements.

(11) The department determines eligibility for institutional services under the GA program described in WAC 388-448-0001 for a client who meets all other requirements for such services but is not eligible for programs described in subsections (8) through (10).

(12) The department determines eligibility for institutional services under the Medically Indigent program described in WAC 388-438-0100 for a client who meets all other requirements for such services but is not eligible for programs described in subsections (8) through (11).

(13) A client is eligible for Medicaid as a resident in a psychiatric facility, if the client:

(a) Has attained institutional status as described in WAC 388-513-1320; and

(b) Is less than twenty-one years old or is at least sixty-five years old.

(14) The department determines a client's eligibility as it does for a single person when the client's spouse has already been determined eligible for LTC services.

(15) The department considers the parents' income and resources available as described in WAC 388-405-0055 (1) (c) for a minor who is less than eighteen years old and is receiving or is expected to receive inpatient chemical dependency and/or inpatient mental health treatment.

(16) The department considers the parents' income and resources available only as contributed for a client who is less than twenty-one years old and has attained institutional status as described in WAC 388-513-1320.

CLARIFYING INFORMATION

Special income level (SIL)

The department compares a client's non-excluded income to the SIL to determine whether a client is eligible for LTC services under the CN program. The SIL is equal to 300% of the SSI Federal Benefit Rate, which is adjusted annually. The department does not allow income disregards when determining eligibility for CN services. It reduces a client's gross income only by the exclusions allowed by federal statute as described in WAC 388-513-1340. The SIL is the maximum amount allowed by law as the CN income standard.

Income transfers

The department considers any agreement between spouses to transfer or assign rights to future income to be invalid when determining a client's income eligibility and participation in the cost of care. The department considers such income available when comparing a client's income to program standards and includes it when determining the

participation amount whether or not the client continues to receive it. The department considers all of a client's income to be available as described in WAC 388-513-1325 and WAC 388-513-1330, unless exceptional circumstances exist that include but are not limited to the following:

- When income is established as unavailable in a fair hearing as described in chapter 388-08 WAC
- When income that at one time belonged exclusively to a client becomes property of the spouse in a community property state. An example of this is when a court divides a pension between spouses by use of a "qualified domestic relations order" (QDRO). Under a QDRO a court transfers a portion of the pension, which it considers a resource, and thereby transfers a portion of the income produced by the resource

The department does not consider income generated by a transferred resource to be available. The income is a part of the resource, which is why the department evaluates the transfer of such an asset as the transfer of a resource as described in WAC 388-513-1365. If a period of ineligibility is required, the department uses only the value of the resource to determine the penalty period of ineligibility.

Private payments to facilities

The department does not count private payments in the form of a deposit or as part of a contract when determining a client's eligibility. If eligibility is established for the period of time for which such payment was made, the facility must refund the amount that exceeds the client's participation in the cost of care. The facility then bills the department and accepts payment as payment in full. If the refund belongs to the client and adding the payment amount to non-excluded resources results in an excess of the resource standard, the department uses it to establish the client's spenddown liability as described in WAC 388-513-1395.

The department does not count private payments made by relatives or others for amenities not provided by the facility when determining eligibility or participation in the cost of care. The definition of income as described in WAC 388-513-1325 and WAC 388-513-1330 does not include such payments.

LTC/Private Insurance

The department does not count LTC insurance payments when determining income eligibility or participation in the cost of care. LTC insurance is considered a third party resource. The department refunds any amount to the client for whom it receives reimbursement as a third party payment when the payment exceeds what the

department has paid for LTC services. The refund becomes a resource in the month it is paid to the client. Spenddown rules apply, if addition of the refund results in an amount that exceeds the resource standard.

Institutionalized SSI Clients

If an SSI client is admitted to a medical facility for a temporary period, SSI payments may continue for the first three months after admission. The department excludes only the SSI benefit when determining eligibility or participation in the cost of care during those months.

Involuntary Treatment Act (ITA)

Under the ITA, clients of any age can be placed into certain institutions for mental diseases (IMD). No face to face interview is required when determining eligibility.

Inpatient mental health treatment in Eastern or Western State Hospital

Persons who are at least twenty-one and less than sixty-five years old who live in Eastern or Western State Hospital are not eligible for medical assistance. Their medical needs are the responsibility of the hospital. As mandated by federal regulations, the department determines eligibility for medical assistance for all persons not disqualified by these age limits and requires participation in the cost of care as described in the program rules.

Parental responsibility

The financial responsibility of parents is limited when their child is receiving inpatient chemical dependency and/or mental health treatment that is expected to last for ninety days or more to what they choose to contribute. This rule remains in effect, even if the expected length of treatment is shortened for any reason.

Residency

The exempt status of the home for a client receiving LTC services in a medical facility or alternate living facility allows for a broad definition of state residency. If the client or client's representative expresses the client's intent to return to the home, it is excluded when determining resources, even if it is located in another state. The expressed intent to return to a home that is in another state does not affect the client's status as a Washington resident.

Nursing facility (NF) - limitations on billing

The NF cannot bill a client who applies for or receives institutional services for the days between admission and the date of request for a CA. The NF cannot bill the department for the client newly admitted for whom a CA has not been requested and completed.

Medicare payment for NF cost of care

Medicare pays the full cost of care for NF services for up to twenty days per benefit period and partial costs for the remainder of one hundred days when the client meets Medicare requirements. If the client enters the NF under Medicare coverage, the department determines eligibility and participation the same as for any other institutionalized client. It considers any unused participation a resource, if the client still has it on the first of the next month.

WORKER RESPONSIBILITIES

1. See **CITIZENSHIP/ALIEN STATUS, RESIDENCY,** and **SSN** to determine whether a client meets general eligibility requirements.

2. See **ADULT MEDICAL, FAMILY MEDICAL PROGRAMS**, **EMERGENCY ASSISTANCE** and **INCAPACITY** to determine the program to which the client can be related to medical eligibility.

3. For a client whose eligibility is established under the alien emergency medical (AEM) or medically indigent (MI) program:

   - Redetermine eligibility every three months
   - Do not limit eligibility to three months in a calendar year
   - Do not apply the emergency medical expense requirement (EMER) when approving services.

4. For a client whose eligibility is established under the general assistance (GA) program:

   - Waive the progressive evaluation process (PEP) for a client who meets program requirements described in WAC 388-448-0001
   - NOTE: To be eligible for waivered services, a GA client must be approved for the GA expedited Medicaid disability (GAX) program

- Determine whether the client should be referred to the CSO SSI facilitator
- (SSIF) for a determination of eligibility for the GAX program
- Include a copy of the comprehensive assessment (CA) when submitting other information as described in the INCAPACITY section to the SSIF.

5. For a client with a potential long-term disability who is not eligible for GA, submit a request to the division of disability determination services (DDDS) as described in the ADULT MEDICAL – SSI-Related Medical section and include a copy of the CA.

6. See WAC 388-513-1350 to establish a client's resource eligibility.

7. See WAC 388-513-1325, WAC 388-513-1330, WAC 388-513-1340, and WAC 388-513-1345 to establish a client's income eligibility. Refer also to WAC 388-506-0620 and the Adult Medical – SSI-related Medical section for a client who is married.

8. If a person is ineligible because of excess income or resources, or does not meet functional eligibility requirements, notify the client of the reasons why the application is denied. Determine eligibility for non-institutional medical assistance as for a client who lives at home.

9. If notice is received that a client no longer needs care provided in a medical facility, request arrangements for an alternate placement from the department designated social worker (SW). Continue current eligibility until such arrangements can be made.

10. If a client who is denied services for not meeting functional requirements requests a fair hearing, notify the SW. The staff person who completed the CA represents the department at the hearing, unless someone else is designated for that responsibility.

11. If the client has LTC insurance, record this information in the TPL section of ACES. Submit coverage information to the Coordination of Benefits (COB) Section of MAA at MS 45561. COB notifies the client of any insurance payments received.

12. Submit any insurance payments received at the HCS or CSO to OFR at MS 45862. Attach insurance information. Tell the client or facility to do the same with any insurance payments received.

13. Follow necessary supplemental accommodation (NSA) procedures described in chapter 388-200 WAC when appropriate.

Inpatient mental health and retardation facilities

1. If it appears that a client admitted to such a facility is eligible for medical benefits, facility staff determine if the client is already approved for a particular program. Facility staff notify the CSO in writing of the client's admission.

2. If a client is not already approved for medical benefits, facility staff assist the client as needed to complete the application and sends it to the CSO. An application is not necessary for a client who is eligible for SSI.

3. Facility staff make referrals as appropriate to the SSIF for a determination of eligibility for the GAX program.

4. When written notification of admission from the facility is received in the CSO, document whether the client intends to return home upon discharge, if the client is a member of a TANF/SFA household (H/H). If so, obtain an estimated length of stay. If not, remove the client from the H/H assistance unit (AU), and determine eligibility for all program benefits as appropriate upon the client's discharge from the facility.

5. If the client intends to return to the TANF/SFA H/H, family members are responsible for the client's personal needs. If the client's length of stay will be:

   (a) Ninety days or less, continue the full grant amount for the client to the AU.

   (b) More than ninety days, reduce the grant amount for the client to the CPI.

6. If a client who was expected to be inpatient for more that ninety days does not remain that long, increase the TANF/SFA grant to the full amount. This does not create an underpayment.

7. If a client who was expected to be inpatient for ninety days or less end up staying longer, reduce the client's grant to the H/H to the CPI amount. This does not create an overpayment.

8. If an SSI-related client is admitted to such a facility and remains there for at least one full calendar month, make program changes in ACES to reflect the change in

the coverage group and living arrangement. Determine eligibility for all program benefits as appropriate upon the client's discharge from the facility.

9. If the client is not discharged and remains eligible for Medicaid, complete an eligibility review (ER) every twelve months. Contact facility staff for information to complete the ER.

10. Follow necessary supplemental accommodation (NSA) procedures described in chapter 388-200 WAC when appropriate.

ACES PROCEDURES

1. Refer to Chapter K 20.16.4 in the ACES User Manual. While following those procedures, the information below is important to remember.

2. ACES medical coverage groups for institutional and waivered programs are in the L, C, K, and G series. Hospice can be entered as a stand-alone program in the C series, or can be approved concurrently with L, C, S, and G02 programs. ACES will allow only one HCB waiver type per AU and it does not support the dual hospice eligibility. Staff must document and create a letter for a client who receives hospice services in conjunction with waivered services.

3. Important screens for LTC programs are STAT, DEM1, INST, SHEL, and LTCD. ACES requires correct Marital Status and Living Arrangement codes on DEM1 for program logic to work correctly. Data input on the INST screen affects the approval for program types and medical coverage groups. Other entries on the INST screen are Housing Maintenance, Dependent Income, and other Expenses. For married clients, enter information on the community spouse's (CS) housing expenses on the SHEL screen. Enter the CS living arrangement, number of dependents, income and resources on the LTCD screen.

4. ACES exempts SSI income from participation for LTC programs. For SSI recipients in a NF, ACES automatically issues a cash grant of $11.62 when SSI benefits are reduced to $30.00. ACES also exempts Veteran's Aid and Attendance (A&A) income. Use source code VT on the UNER screen when entering the A&A income amount.